Essential Health Benefit Public Comments

Virginia Association of Community Services Boards

Virginia Association of Nurse Anesthetists

Individual Comment

Voices for Virginia's Children

Virginia Optometric Association

National Association of Mental Illness – Virginia Chapter

State Association of Addiction Services

Pharmaceutical Research and Manufacturers of America

March of Dimes

Virginia Dietetic Association

International Myeloma Association

DentaQuest

Alliance of Virginia Dental Plans

United Concordia Dental

My name is Michael Sizemore and I am here on behalf of the Virginia Association of Community Services Boards. I want to first thank everyone involved with the Virginia Health Reform Initiative for your contributions to the Commonwealth.

The VACSB represents 39 Community Services Boards and one Behavioral Health Authority, all of whom have extensive experience in developing, managing, and providing services for individuals with behavioral health conditions and developmental disabilities. It's this experience that proves that treatment must be accessible and must be coordinated with all necessary health care providers. Treatment does produce healthier outcomes. Treatment does produce fewer hospital visits. And treatment does produce healthier communities with consumers employed and in school in much higher numbers.

As stated previously and in the bench mark study, behavioral health services are not well-defined or easily accessible and understood by the population that most need them. I want to reinforce that the opportunity Virginia now has to define them is imperative, just as much as it is to define benefits for individuals with diabetes or any other serious medical condition. The stakes are too high, and the results that are achieved when appropriate services are provided are too well-documented to ignore.

As I stated at the last VHRI hearing, and based on our extensive experience and expertise of all 40 of our member boards, we had recommended **two tiers of cost effective behavioral health services based on severity, complexity and acuity of illness**. At the very least, the Tier I services that VACSB has defined should be part of the Virginia Essential Health Benefits package, should be clearly defined for consumers of those services, and should be easily accessed when needed. In short, they should be available in parity with other medical health services.

Tier I services consists of traditional behavioral health services designed to address and resolve a wide variety of mental health and substance use disorders. These basic services allow individuals to stay employed in their community, stay in-school, and allow them to avoid costly trips to the emergency room. They include medication, outpatient counseling, partial hospital treatment, and inpatient treatment. If these services are not included in the Anthem PPO, they should be added or purchasers will not be well served.

Tier II services consists of highly i**ntensive** behavioral health services that may continue for an extended period of time and serve to avoid hospitalizations of children and adults who have serious mental illness, emotional disturbance, or co-occurring substance use disorders and who

are so impaired by their illnesses that they need considerable assistance in remaining in their communities and providing for their basic needs. The genesis of these Tier II services is based around avoiding hospitalization. While they may not apply to the needs of the general population, it may be worthwhile to consider the formulation of specialty plans that consumers may purchase should there be any indication of need.

Again, we want to thank you for your hard work on this area and we look forward in working alongside VHRI in finding cost-effective, ethical, and results-oriented services for Virginia.

Contact Information:

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VANA
Virginia Association of Nurse Anesthetists
1934
CRNA

June 5, 2012

BY EMAIL
The Honorable Cindi Jones
Director
Virginia Health Reform Initiative
1111 East Broad Street
Richmond, VA 23219

RE: Written Public Comment Regarding Essential Health Benefits

Dear Ms. Jones,

I am writing on behalf of the Virginia Association of Nurse Anesthetists ("VANA") to thank the members of Virginia Health Reform Initiative Committee members for their hard work and dedication to advancing health care in the Commonwealth, and to ask that any Health Benefit Exchange plan include and recognize Certified Registered Nurse Anesthetists (CRNAs) as reimbursable providers, or at a minimum, include provider neutral language that does not provide preference for one healthcare provider over another.

VANA was founded in 1934 and represents 90% of Virginia's CRNAs. In Virginia, CRNAs are licensed and regulated as Nurse Practitioners. CRNAs are advanced practice nurses who have graduate preparation at either the Master's or Doctorate level.

CRNA's are involved in over 95% of the anesthetics delivered in Virginia and play a critical role in surgical procedures. CRNAs practice in every setting in which anesthesia is delivered, including traditional hospital surgical suites and obstetrical delivery rooms; critical access hospitals; ambulatory surgical centers; the offices of dentists, ophthalmologists, plastic surgeons, and pain management specialists; and U.S. military, public health services and Department of Veterans Affairs healthcare facilities.

In rural settings, CRNAs are often the only anesthesia providers, allowing healthcare facilities in medically underserved areas to offer obstetrical, surgical, and trauma stabilization services—services the facility might not otherwise have the ability to provide.

As cost-effective, qualified anesthesia providers, it is critical that CRNAs are included as a provider in any benefit plan, or at a minimum, the plan is provider neutral so as to allow the citizens of the Commonwealth the greatest level of access to quality anesthesia care.

VANA appreciates the opportunity to comment. Please do not hesitate to contact me if you have additional questions.

Sincerely,

/c/ Cathy Harrison

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To Honorable Bill Hazel, Secretary of Health and Human Resources, Commonwealth of Virginia
and
Cynthia Jones, Director, Virginia Health Reform Initiative
Thank you for the opportunity to comment, for your June 13 meeting, per email announcement of June 6, with comments due June 8.

Respectuflly,

We comment regarding item 1. Essential Health Benefits, referring to VHRI document found at http://www.hhr.virginia.gov/initiatives/healthreform/meetingresources/VAEssentialBenefitsAnalysis.pdf

We note that acupuncture is discussed in a way that suggests it will be outside coverage. Yet, acupuncture is shown to be well researched, commonly practiced with complete safety and with few side effects - including in less-costly and more accessible community settings - with powerful benefits for reducing symptoms of stress, ptsd, and trauma. These important features are particularly relevant to wounded warriors/veterans (see at http://www.rehab.research.va.gov/jour/2012/493/sniezek493.html). Acupuncture should be covered among essential health benefits.

We note that coverage of bariatric surgeries are considered to be covered, although costly to all premium payers. Long-term effectiveness, for diverse populations, is questionable (see at http://www.ama-assn.org/amednews/2009/05/04/hlsd0504.htm). Further, bariatric surgery does not prevent incidence of overweight and obesity; and does not prevent, or treat, overweight and obesity in children, which is a growing edge of childhood diabetes, and onsets of various other diseases, lack of effective learning in school, and lack of readiness for work life. The medical, behavioral health, and public health literatures support use of nutritional counseling, exercise, peer support and other programs, in diverse social-structural settings (at work, at school, in congregations, in the community) (for example see at http://content.healthaffairs.org/content/28/1/46.full). A range of effective programs to prevent, and to treat, overweight and obesity should be covered.

Sixty percent or more of Fortune 500 companies choose to offer health benefits to their employees' family household members without limiting such coverage to those related by blood or marriage. At least 12 Virginia-based Fortune 500 or Fortune 1000 companies offer such benefits including: Altria Group, Capital One, CarMax, Dominion Resources, Gannett, Genworth, MCI Group, MeadWestvaco, Owens & Minor, Philip Morris USA, SprintNextel, and SLM Corp. (Sallie Mae). The Employee Benefit Research Institute (EBRI) in Washington D.C. reports that for 85 percent of companies including these family members adds less than 1 percent to the total cost of the health-care benefit, and less than 1.2 percent of eligible employees enroll in coverage for famiy household members, including domestic partners and children of domestic partners. Virginia - which prides itself on its 'business minded' and 'business friendly' policy milieu and practices - should follow the lead of leading business and include family household members as eligible for coverage. And, if not, VHRI should explain why it opposes this common-sense business practice.

Thank you for this opportunity to speak, particularly for our wounded warriors, diverse Virginia families, and regarding the bankrupting potential of unchecked incidence and prevalence of overweight and obesity.

Edward Strickler, MA, MA, MPH and others
Albemarle County VA

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Voices for Virginia's Children
Comments to Virginia Health Reform Initiative Advisory Council
6/8/12

Voices for Virginia's Children has concerns about the benchmark essential health benefits package being proposed by the VHRI Advisory Council as it relates to children's mental health.

The Virginia Department of Behavioral Health and Developmental Services estimates that as many as 100,000 children and adolescents in the Commonwealth suffer from a SERIOUS mental health condition- diagnoses like depression, anxiety, bipolar disorder, and ADHD. Based on these numbers, decisions made in Virginia about essential benefits will have huge consequences for the health of our children and our future adult population.

It is well known in the field of children's mental health that a comprehensive array of services is the most **effective** in treating the variety of serious emotional disturbances suffered by children. It is also the most **cost-effective**, as community-based services can often prevent children from being hospitalized or going into costly, out-of-home placements to treat their mental health disorders. For these reasons, national experts in children's mental health including the Bazelon Center for Mental Health Law and the Georgetown University Training and Technical Assistance Center recommend that essential benefits plans cover an array of mental health services for children, not only in the categories of mental health/substance abuse services but also in the prevention, habilitation and rehabilitation, and chronic disease management categories.

Children with serious mental health disorders who do not receive the appropriate level of treatment often become financial burdens on the state: they turn to Comprehensive Services Act funding or become Medicaid-eligible after being out of the home for 30 days. If their conditions go untreated, they are more likely to experience school failure and drop out, become involved in the juvenile justice system, and abuse substances. All of these negative outcomes carry a cost to the taxpayer (in addition to the human toll), whether it is through remedial education, juvenile justice or law enforcement costs.

In order to prevent this cost-shifting of the burden of mental health treatment, the essential health benefits must cover a range of treatment options. The Anthem PPO proposed to be used as the benchmark plan for Virginia only covers inpatient treatment, partial day treatment (largely if not totally non-existent for children), outpatient treatment and medication management.

To avoid inpatient treatment, many children with serious mental health diagnoses need services more intensive than just typical outpatient services and medication management. Evidence-based treatment options include:

- Intensive in-home services
- Crisis services
- Therapeutic day treatment

- Comprehensive case management
- Family/peer support services

Thank you for considering this input.

Margaret Nimmo Crowe
Policy Director
Voices for Virginia's Children

VIRGINIA OPTOMETRIC ASSOCIATION

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June 7, 2012

To: Virginia Health Reform Initiative Advisory Council
VHRI@governor.virginia.gov

Comments Regarding Essential Health Benefits, for June 13th VHRI Meeting:

The Virginia Optometric Association represents Virginia's doctors of optometry who are geographically distributed throughout the entire Commonwealth. Optometrists are the primary eye care providers for over 70% of the residents of Virginia, providing services which range from comprehensive eye examinations to determine refractive error and diagnosis of eye disease, to prescribing and dispensing prescription eyewear, to treatment of sight threatening eye disease such as glaucoma.

Virginia's doctors of optometry provide services which clearly fall under the Affordable Care Act's required Essential Health Benefits. These include:

Ambulatory Services:	diagnosis and treatment of eye abnormalities, conditions and diseases for all ages, including pediatric and adult patients.
Rehabilitative Services:	vision rehabilitation, including but not limited to low vision services and aides, and vision therapy/orthoptics following stroke or traumatic brain injury.
Pediatric Vision Services:	comprehensive examination to evaluate and diagnose refractive error, but additionally for ocular disease and abnormalities, including amblyopia and strabismus conditions, which must be treated at an early age to prevent "lazy eye."

To ensure the delivery and availability of the required Essential Health Benefits, it is imperative that these **vision, eye/health related services (all required under the ACA) may be provided by both optometrists and ophthalmologists. Patients should be granted freedom of choice of eye care provider** which brings the added benefit of reduced costs to the system by increased competition between and access to more cost effective provider types.

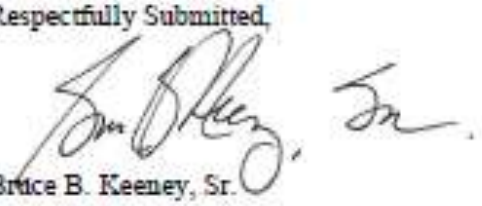
(continued)

It is important to note that the ACA specifies that both pediatric dental and vision services are required, essential health benefits. For clarity and to conform with guidance provided by federal agencies, it is likewise imperative that **pediatric vision services be defined as a comprehensive eye examination rendered by an optometrist or ophthalmologist.** In that the federal government has not yet provided any guidance as to whether or not pediatric vision services are to include prescription eyewear, we recommend such be stated as an optional benefit. In brief, we encourage the definition of Essential Health Benefits **clearly state that pediatric vision services shall mean a comprehensive eye examination provided by an optometrist or ophthalmologist of the patient's choice, and that the plan not be required to cover prescription eyewear or contact lenses but may do so at an additional cost to the subscriber/enrollee.**

Note we are NOT recommending, at this time, the coverage of additional services.

Our two recommendations are to ensure that required essential health benefits are included and accessible, and in compliance with the ACA.

Respectfully Submitted,



Bruce B. Keeney, Sr.
Executive Director & Legislative Counsel
Virginia Optometric Association

cc: Chris Holcomb, O.D., F.A.A.O.
Chair, Health Reform Initiative Task Force
Virginia Optometric Association

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Comments to the Virginia Health Reform Initiative on Essential Health Benefits and Navigators for the June 13, 2012 Meeting
Submitted by the National Alliance on Mental Illness of Virginia

Prevalence

The Virginia Department of Behavioral Health and Developmental Services estimate that as many as 306,000 adult Virginians have a serious mental illness at any time during a given year. And 100,000 children and adolescents suffer from a serious mental health condition. Thus the health benefits exchange have the opportunity to have a major impact on many individual lives, families, communities, and the overall health and well-being of our Commonwealth. Why is this important?

Costs associated with untreated mental illness and substance use disorders

It is well known that there are major costs and impacts associated with untreated mental illnesses and substance use disorders. Homelessness, chronic health care needs, unemployment, family trauma and disruption, and school disruption are just a few of the associated costs.

- Social and economic effects of bipolar disorder include functional impairment, disability or lost work productivity, and increased use of health services. Evidence for these impacts include cross-sectional studies, longitudinal studies, and true experiments (randomized trials of specific treatments or treatment programs).
- **In the United States, the annual economic, indirect cost of mental illness is estimated to be $79 billion.** Most of that amount—approximately $63 billion—reflects the loss of productivity as a result of illnesses. *U.S. Department of Health and Human Services. Mental Health: A Report of the Surgeon General. Rockville, Md., U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 1999, pp. 408409, 411.*
- **Over 50 percent of students with a mental disorder age 14 and older drop out of high school**—the highest dropout rate of any disability group. *U.S. Department of Education. Twenty-third annual report to Congress on the implementation of the Individuals with Disabilities Act. Washington, D.C., 2006.*
- **The average annual cost of serving an individual in a state-operated psychiatric hospital in Virginia is $214,000.** *Department of Behavioral Health and Developmental Services, Major Issues Facing the Commonwealth's Behavioral Health & Developmental Services System; Presentation to Senate Finance Committee, 2011.*
- Individuals living with serious mental illness face an increased risk of having chronic medical conditions. Adults living with serious mental illness die 25 years earlier than other Americans, largely due to treatable medical conditions. *Manderscheid, R., Druss, B., & Freeman, E . (2007, August 15). Data to manage the mortality crisis:*

Recommendations to the Substance Abuse and Mental Health Services Administration. Washington, D.C.

Treatment for mental illness/substance use disorder works if you can get it.

A substantial body of national and state-outcomes research supports the efficacy of a wide range of mental health treatments. Examples in Virginia: Programs of Assertive Community Treatment (PACT) Outcomes in FY2008 (nearly 1,000 consumers):

- Use of state hospital beds was reduced by 69%
- 86% had stable housing
- 89% lived in private households
- 93% had no arrests
- 16% had some employment experience
- **(2001 study data) 75% of the reduction in state hospital stays post-PACT enrollment is due to PACT as opposed to "services as usual."**

Yet not everyone gets the treatment that they need.

- **One-half of all lifetime cases of mental illness begin by age 14, three-quarters by age 24. Despite effective treatments, there are long delays**—sometimes decades—between the first onset of symptoms and when people seek and receive treatment. *Wang, P., Berglund, P., et al. Failure and delay in initial treatment contact after first onset of mental disorders in the National Co-morbidity Survey Replication (NCS-R). General Psychiatry, 62, June 2005, 603-613.*
- **Fewer than one-third of adults and one-half of children with a diagnosable mental disorder receive mental health services in a given year.** *U.S. Department of Health and Human Services. Mental Health: A Report of the Surgeon General. Rockville, Md., U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 1999, pp. 408409, 411.*

Essential Health Benefits

With respect to adults with serious mental illness and children and youth with serious emotional disorder an essential benefits package should aim to:

- Speed crisis stabilization and recovery of acute crises, leading to better outcomes and the likelihood of returning to one's home
- Improving long-term stability, functioning, and recovery and improve the likelihood of successful independent living
- Reduce the likelihood of relapse and rehospitalization
- Reduce the likelihood of homelessness and/or incarceration
- Identify and address secondary health issues
- Facilitate the return to work, community engagement, family responsibilities, and other meaningful activities enjoyed by the general public

It is critically important that the EHB package is designed in a way that ensures that the mental health and substance use disorder needs of children, youth, adults, and elderly persons are well

met. A robust, comprehensive array of services has the potential to prevent unnecessary hospitalizations through the involuntary commitment process, avoid crisis and costly trips to the emergency room, keep people employed, and keep children in schools and out of costly residential treatment centers.

Regarding the Anthem PPO plan as the potential benchmark plan, while we are pleased that the following services are included as covered services -- medication, outpatient counseling, partial hospital treatment and inpatient treatment, we believe that the EHB package could be even more comprehensive, again, for the purpose of preventing unnecessary hospitalizations, avoiding costly trips to the emergency room, and keeping children in schools and out of costly residential treatment programs.

We offer the following specific benefit recommendations to ensure adequate coverage for mental health and substance use disorders, which have been endorsed by the Coalition for Whole Health, a coalition of national and state organizations that brings together advocates from the mental health and substance use disorder fields for a united force working toward the best care under the Affordable Care Act. The National Alliance on Mental Illness is part of that coalition.

Mental Health and Substance Use Disorder Services

- Outpatient treatment
- Inpatient hospital services
- Intensive outpatient
- Intensive home-based treatment
- Crisis services
- Residential substance use disorder treatment

Prescription Drugs

Prescription drug coverage must include coverage for all medications approved for the treatment of mental illness and substance use disorders

Rehabilitative and Habilitative Services and Devices

- Psychiatric rehabilitation skills training and other services
- All clinically appropriate treatments for eating disorders
- Recovery support services, including peer support and coaching

Pediatric Services

- Prevention, Early Identification, and Treatment

Preventive and Wellness Services

- Home visiting programs
- Wellness Services
- Prevention services including those required by the ACA, and suicide and drug screenings for adults
- Individuals and families, across the lifespan, should have coverage to receive education and skills training about preventing, treating, and recovering from substance use and/or mental disorders.

Chronic Disease Management

- Comprehensive care management
- Care coordination and health promotion
- Patient and family support
- Appropriate referral to community and social support services

Navigators/Brokers/Third Party Administrators

The population that is expected to utilize the Exchange:

- Will be new to the insurance market, mostly likely un- or underinsured previously and most likely new to the process of choosing a plan
- May be looking for certain covered services
- May need additional time and guidance from the Navigators
- Should be able to ask for another Navigator if they are not comfortable with the discussion and guidance they are receiving

- The exchange should limit the incentive of "Broker-Navigators" to direct business to health plans outside of the exchange. The role of Brokers-Navigators should be to inform consumers and others about the insurance options available to them. It should not be to direct consumers to the insurance product for which the Navigators/brokers have the greatest financial incentive. The Navigator program is set up to protect the consumer, not to preserve financial arrangements of brokers or other entities. As a condition of participating in the exchange, brokers should have to disclose the fees they receive to show that they have no increased financial incentive to steer business away from the exchange. Some uniform limits on broker fees should also be considered.

- If there is legislation that addresses the role of brokers, no certification requirements should be included that would prevent direct service providers, community based organizations and others working with low-income populations from operating as Navigators. In fact, if addressed in the legislation, statutory language should specifically authorize those entities to serve as navigators.

- The Navigator programs should include training on working with diverse populations with diverse health needs, including people living with mental illness. Navigators should receive specific training and work closely with consumer groups to ensure that individuals with chronic health conditions, including mental illness and substance abuse conditions, are connected to health insurance coverage that is appropriate for their needs.

Contact Information
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State Association of Addiction Services

June 7, 2012

Virginia Health Reform Initiative Advisory Council
VA Department of Health Professions
Commonwealth Conference Center
9960 Mayland Drive
Henrico, Virginia 23233

RE: Recommendations for Essential Health Benefits

Dear Advisory Council Members,
We are representing both the State Associations of Addiction Services (SAAS) and the Coalition for Whole Health of which SAAS is an integral member. The Coalition for Whole Health is a broad coalition of local, State, and national organizations in the mental health and substance use disorder prevention, treatment, and recovery communities. We realize the magnitude of your charge in providing recommendations on the structure and selection of an Essential Health Benefit (EHB) and Benchmark Plan for the Commonwealth.

With that goal in mind, attached for your review and consideration, is an "EHB Consensus Principles and Services Recommendations" that outlines recommendations for mental health and substance use disorders treatment and services that should be included in any EHB package. These principles and recommendations have been fully endorsed by the Coalition for Whole Health membership. We hope that it will prove useful as you deliberate the options and choices that will provide all Virginians with accessible and comprehensive health care coverage and benefits.

Please consider SAAS and the Coalition for Whole Health as resources for the work you have undertaken. We are happy to answer your questions and provide you with additional resources and background to meet your needs. Please contact me at 202.546.4600 or at epastore@saasnet.org.

Respectfully submitted,

Enzo Pastore, MSS, MLSP
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EHB Consensus Principles and Service Recommendations

The success of national health care reform will be judged on its ability to provide essential services to all Americans, improve overall health outcomes, and control costs. The Affordable Care Act's (ACA) inclusion of mental health (MH) and substance use disorder (SUD) benefits as essential health benefits (EHB) demonstrates clear understanding that meeting individuals' mental and substance use disorder needs is integral to achieving all these goals by improving and maintaining Americans' overall health and reducing the enormous health care costs that result when these illnesses are not treated.

As the federal Department of Health and Human Services (HHS) develops final guidance on EHB and state policy-makers move forward with ACA benefit design, the Coalition for Whole Health offers the below recommendations about the MH and SUD services that should be included in the EHB.

Introduction

Substance use disorders and mental illnesses are treatable health conditions, as accepted by the American Medical Association, all other public health and medical standards, and decades of scientific research. Tens of millions of adults and youth are in need of care: in the last year, nearly one-third of adults and one-fifth of children had a diagnosable substance use or mental health problem. However, there remains an unacceptably large MH and SUD treatment services gap in this country. In the past year, less than half of the 15 million adults with serious mental illness received psychotherapeutic treatment or counseling for a mental health problem and only ten percent of the over 23 million people in need of care for a SUD received any specialty treatment. As a result, individuals with co-occurring mental illness and substance use disorders have life expectancies 35 years shorter than individuals without these illnesses.

With passage of the federal parity law in 2008, Congress recognized the long history of widespread discrimination in private insurance coverage of MH and SUD benefits and sought to remedy this inequity. In addition to historically weak coverage of MH and SUD benefits through private insurance, Medicaid coverage of SUD services and to a lesser extent MH care varies widely across the country. By extending the requirements of the federal parity law to all qualified health plans under the ACA, Congress has ensured significant improvement in access to these critical services.

It is important to note that looking to "typical employer coverage" prior to full implementation of the parity law is insufficient. Not only will large employer plans' MH/SUD coverage improve as a result of that law, insurers typically pay for certain MH/SUD services that are not identified as covered benefits in their materials. For example, a 2011 analysis by Milliman and the recent Institute of Medicine (IOM) report on the EHB found a considerable number of MH/SUD services are included in a majority of employer health plans, including many that are classified as "rehabilitation." The IOM also recognized the limitations looking at "typical employer coverage" for certain types of benefits including MH and SUD benefits by recommending in their report that HHS should look to the scope of Medicaid coverage in states that cover MH and SUD to better ensure that these individuals' needs are well met. Our EHB recommendations are based on a review of which MH and SUD services have typically been offered through employer plans, as well as focusing on evidence-based practices that are effective and necessary to help people become and stay well.

Benefit Recommendations

It is critically important that the EHB package is designed in a way that ensures that the MH and SUD needs of children, youth, adults, and elderly persons are well met. As national organizations working to ensure the ACA is effectively implemented for people with SUD and MH service needs, we offer the following specific recommendations to ensure adequate coverage for MH and SUD conditions:

Mental Health and Substance Use Disorder Services

- Outpatient treatment

  To include all services traditionally covered by insurance, such as assessment, treatment planning, laboratory services, individual, group and family evidence-based psychotherapy services, appropriate medication prescribing and monitoring. Outpatient treatment should also cover screenings, referral, and ambulatory detoxification

- Inpatient hospital services

  To include all services traditionally covered by insurance, including detoxification and psychiatric stabilization services

- Intensive outpatient

  To include all intensive outpatient and partial hospital services traditionally covered by insurance for the treatment of substance use disorders

- Intensive home-based treatment

  To include all services traditionally covered by insurance for children and adults with serious mental illness and/or substance use disorders, such as counseling, behavior management, and medication management

- Crisis services

  To include emergency room crisis intervention, stabilization, and mobile crisis services

- Residential substance use disorder treatment

  To include all services traditionally covered by insurance related to residential substance use disorder treatment (sub-acute treatment) that correspond to the American Society of Addiction Medicine's level III of care

Prescription Drugs

- Prescription drug coverage must include coverage for all medications approved for the treatment of mental illness and substance use disorders

Rehabilitative and Habilitative Services and Devices

- Psychiatric rehabilitation skills training and other services

  To include all services traditionally covered by insurance, including skills training to address functional impairments, furnished in any appropriate setting, and also to include rehabilitation services designed to avoid institutional placement for children and adults with severe mental illness, such as therapeutic foster care
- All clinically appropriate treatments for eating disorders
- Recovery support services, including peer support and coaching

Pediatric Services

- Prevention, Early Identification, and Treatment
  Age appropriate outpatient, inpatient, and home-based pediatric mental health and substance use disorder prevention services, screenings, treatment, recovery and rehabilitative services, so as to provide equivalent coverage to that for adults

Preventive and Wellness Services

- Home visiting programs
  Evidence-based home visiting for caregivers, infants and toddlers

- Wellness Services
  Consumer and family education on maintaining healthy weight, good nutrition, substance use prevention, and other aspects of a healthy lifestyle, including wellness

- Prevention services including those required by the ACA, and suicide and drug screenings for adults

- Individuals and families, across the lifespan, should have coverage to receive education and skills training about preventing, treating, and recovering from substance use and/or mental disorders.

Chronic Disease Management

- Comprehensive care management
  Intensive case management for persons with severe mental illness and substance use disorders

- Care coordination and health promotion
  Including care coordination services for children, adults, and elderly persons with mental illness and substance use disorders

- Patient and family support
  Including education and self-management assistance for persons with severe mental illness and substance use disorders

- Appropriate referral to community and social support services

Meeting the ACA's Requirements for MH and SUD

The EHB must comply with the requirements of the ACA regarding parity and non-discrimination. Under the Mental Health Parity and Addiction Equity Act of 2008, coverage of mental health and substance use disorders may not be more restrictive than coverage of other medical/surgical benefits by the plans.

In addition, the requirement in the ACA that the Secretary shall ensure that health benefits established as essential not be subject to denial based on age, expected length of life, present or predicted disability, or quality of life has very significant implications for individuals with MH and/or SUD. This means that none of the categories of essential health benefits may result in discrimination with respect to children, adults, or elderly persons with severe mental illness or substance use disorders. This language is particularly relevant with respect to rehabilitation services and chronic disease

management. Enforcement of these protections must be included among the highest priorities for implementation and ongoing administration of the ACA.

MH and SUD services that reflect the latest and best available evidence-based or consensus-based practice should be included in the essential health benefit. The health insurance exchange and Medicaid benchmark plans should employ appropriate quality measures for MH and SUD services aimed at producing the best possible outcome for each individual. These measures should be used in performance-based payment plans.

Our benefit recommendations are intended to apply as the foundation for all qualified health plans. However, this basic set of benefits will not adequately address the health needs of every enrollee, particularly those individuals with serious chronic conditions such as serious mental illness and substance use disorders. Many health plan enrollees with incomes moderately higher than Medicaid eligibility, as well as individuals who receive coverage of limited benchmark Medicaid plans will require additional services. We encourage the Department to work with States to ensure the health needs of these individuals will be met.

As recommended by the Institute of Medicine, there should be a formal mechanism to ensure that individuals with substance use disorder and/or mental health needs and their family members are partners with care providers in designing and implementing service plans. Policies should be in place to implement informed, patient-centered participation and shared decision-making in prevention, treatment, illness self-management and recovery plans and strategies. Individuals and their families should be educated participants in the design, administration and delivery of prevention, treatment, rehabilitation, and recovery support services.

The ACA requires that the EHB package reflect balance among the ten broad benefit categories. Millions of children, youth and adults are affected by MH and SUD and there remains an unacceptably large treatment gap for care. People with MH and SUD will not only need a strong benefit representing the continuum of care in the “mental health and substance use disorders services, including behavioral health treatment” benefit category, but will also need good coverage under all of the other categories. The EHB package as a whole should reflect an appropriate balance of services that ensures enrollees can access medically necessary care to avoid disease, become well and maintain long-term wellness.

The EHB should be designed so that it can be updated at regular intervals to reflect new treatments and medications that have been shown to be appropriate and effective. Technology is changing and new drugs and treatment interventions are being introduced to provide MH and SUD care. In addition, similar to the lack of adequate research on services to treat other health conditions, there is a need for additional research on MH and SUD services.

We urge the Commonwealth to continue to monitor implementation of the federal parity law and review what typical employer coverage looks like after full implementation. Lessons learned from parity law implementation should inform the discussion about how to update mental health and substance use disorder benefits in essential health benefits package.

National healthcare reform presents us with a tremendous opportunity to improve public health, reduce costs, and ensure coverage and access to necessary care for all Americans. With full implementation of the ACA, millions of Americans with limited or no access to MH and/or SUD services will have coverage for these services, many for the first time. Inclusion of the range of effective MH and SUD prevention,

treatment, rehabilitation, and recovery support services will result in significant cost-savings to the healthcare system and ensure that millions of people lead healthy lives.

The Coalition for Whole Health

Kristin Parde
Senior Director
State Policy

PhRMA

June 7, 2012

VIA ELECTRONIC FILING – VHRI@governor.virginia.gov

Ms. Cindy Jones
Director
Virginia Department of Medical Assistance Services
600 East Broad Street
Richmond, VA 23219

Re: Essential Health Benefits

Dear Ms. Jones:

The Pharmaceutical Research and Manufacturers of America (PhRMA) appreciates the opportunity to comment on the Virginia Health Reform Initiative's stakeholder request regarding Essential Health Benefits (EHBs). PhRMA is a voluntary, non-profit organization representing the nation's leading research-based pharmaceutical and biotechnology companies, which are devoted to inventing medicines that allow patients to lead longer, healthier, and more productive lives.

We appreciate the Commonwealth's attempts to engage stakeholders on this important subject. We offer the following comments for consideration:

- **Comprehensive prescription drug coverage is important to effective, high-quality care.** Standards to ensure that qualified health plans (QHPs) offer comprehensive prescription drug coverage, including generic and brand medicines, are key to providing high quality, coordinated medical care. Comprehensive prescription drug coverage is particularly important to providing access to needed care for patients with chronic conditions and to reducing long term health costs by avoiding unnecessary hospitalizations and medical care that could be prevented.
- **Assuring patient and provider choice of medicines is a pathway to avoiding discriminatory plan design.** Requiring plans to include just one drug per therapeutic class is insufficient to ensure patient access to needed care -- as is evident from a review of widely-agreed upon standards of care, such as those established by respected medical professional societies, or information on the face of an FDA-approved product's label. Furthermore, this standard leaves open the potential for benefit designs that would discourage the enrollment of individuals with significant health care needs. Establishing such a low standard could potentially reset the market by encouraging new designs far below current standards of care and typical of employer coverage today.

- **Virginia should establish clear and meaningful standards for comparing qualified health plans to the benchmark plan.** In order to maintain quality health care, the Commonwealth should develop a clear methodology for comparing QHPs to the selected benchmark plan. Actuarial equivalence will not be sufficient to ensure that plan coverage is clinically adequate. Therefore, Commonwealth should develop guidelines for qualified health plans that reflect multiple aspects of coverage, including the degree of choice available to patients and providers; processes for updating coverage to reflect newly available treatments; and protections for vulnerable populations.

I. Prescription Drug Coverage is Important to Effective, High-Quality Health Care

The Affordable Care Act's (ACA's) requirement for qualified plans in the exchange to cover prescription drugs and vaccines[1] recognizes that coverage of prescription medicines is standard in commercial insurance products and, equally important, the role that medicines play in modern health care. Comprehensive prescription drug coverage -- whether for medicines covered by the outpatient pharmacy benefit or as part of the medical benefit, such as drugs administered incident to a physician's service—is important to preventing, treating, and potentially curing serious and chronic medical conditions, as well as improving quality of life and reducing health care costs. Over the last several decades, new medicines have made it possible to prevent or slow the progress of many diseases, thereby reducing costly hospitalizations and other expensive medical and surgical procedures.

Recent medical advances, particularly those related to prescription medicines, have provided enormous clinical and economic value. As summarized by CBO, "Many examples exist of major therapeutic gains achieved by the industry in recent years…anecdotal and statistical evidence suggests that the rapid increases that have been observed in drug-related R&D spending have been accompanied by major therapeutic gains in available drug treatments."[2] For instance, The Centers for Disease Control and Prevention identified "new drugs and expanded uses for existing drugs" as contributing to the decline in heart disease and stroke mortality.[3] Academic researchers associated new medicines with declines in mortality for breast cancer[4] and other cancers,[5] reduced disability rates among elderly persons,[6] and increased productivity among workers with conditions like rheumatoid arthritis.[7]

In addition, it is crucial to recognize the role that prescription drugs can play in reducing long term costs of care by avoiding unnecessary hospitalization and institutional costs. [8] For example, a recent study in the *American Journal of Cardiology* found that patients with high rates of adherence to statins had significantly lower total health care cost and lower risk of cardiovascular disease-related hospitalizations, relative to non-adherent patients. Authors estimated that increasing adherence rates to statin therapy could potentially save the U.S. healthcare system more than $3 billion annually.[9] Similarly, studies on diabetes

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[1] Section 2713 of the ACA requires a group health plan or individual insurance issuer to provide coverage without imposing any cost sharing requirements for immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

[2] Congressional Budget Office, "Research and Development in the Pharmaceutical Industry," October 2006.

[3] Centers for Disease Control and Prevention, National Center for Health Statistics. "Health, United States, 2006: With Chartbook on Trends in the Health of Americans," Hyattsville, MD, 2006.

[4] SK Chia et. al, "The Impact of New Chemotherapeutic and Hormone Agents on Survival in a Population-Based Cohort of Women with Metastatic Breast Cancer," Cancer 2007; 110.

[5] Lichtenberg, FR. "The Expanding Pharmaceutical Arsenal in the War on Cancer." National Bureau of Economic Research Working Paper 10328, February 2004.

[6] "Intensive Medical Care and Cardiovascular Disease Disability Reductions," forthcoming in David Cutler and David Wise, eds., Health at Older Ages: The Causes and Consequences of Declining Disability Among the Elderly, Chicago: University of Chicago Press, 2008 (with Mary Beth Landrum and Kate Stewart).

[7] Integrated Benefits Institute, "A Broader Reach for Pharmacy Plan Design," May 2007.

[8] J.M. McWilliams et al. "Implementation of Medicare Part D and Nondrug Medical Spending for Elderly Adults with Limited Prior Drug Coverage," Journal of the American Medical Association, 27 July 2011.

[9] D.G. Pittman et al. "Adherence to Statins, Subsequent Healthcare Costs, and Cardiovascular Hospitalizations." American Journal of Cardiology, June 2011.

show that adherent patients are half as likely to have a heart attack, undergo amputation or treatment for an ulcer, or experience an adverse renal event potentially leading to kidney disease.[10] Facilitating restricting access to medicines in the service of achieving short-term, line item savings would lead to poorer utilization patterns, generating poor clinical outcomes, and higher costs on other services.

Assuring provider and patient choice of medicines is essential to ensuring that benefits meet patients' diverse health care needs. Patients often respond to medicines differently; maintaining broad access to medicines is essential to ensuring these patients have access to multiple treatment options as often multiple medicines must be tried before an adequate response is achieved.

It is important for quality health insurance to reflect the needs of patients with chronic conditions. A new study by economists at the University of Minnesota, University of Wisconsin-Madison, and Indiana University found that employer-sponsored insurance for the chronically ill is less generous than insurance for those without a chronic condition, primarily due to higher cost sharing for prescription drugs.[11] The researchers conclude that "it is benefit design, not differences in the types of plans covering the [chronically ill and non-chronically ill], that explains the difference we observe in insurance generosity....the specific services used most by the chronically ill—prescription drugs—are, by design, reimbursed at a lower rate." It would be counterproductive, and inconsistent with the goals of achieving better access to care, improved quality and cost savings, and balance among categories of services, to establish standards such as the one drug per class rule that would result in systematically poorer coverage (including effectively no coverage of many needed medicines) for the many patients with chronic conditions. This large group of patients would, by definition, suffer the consequences of inadequate coverage year after year given the persistency of their conditions.

The challenges of developing essential benefits and coverage in the insurance exchange will require drawing on best practices in and lessons from the employer sponsored market, FEHBP, and Medicare Part D, each of which offer successful models for recognizing the essential role of medicines, protecting beneficiaries, and promoting access to care, while maintaining affordability. Medicare Part D for example, has provided broad access to medicines, with high beneficiary satisfaction rates and at lower costs than originally anticipated.[12] Moreover, Part D has shown reductions in non-drug spending associated with gaining comprehensive drug coverage. Harvard researchers report savings in hospital and skilled nursing facility costs of about $1,200 per newly insured beneficiary,[13] or about $13.4 billion in 2007,[14] the first full year of the Part D program.

II. Proposed "One Drug per Class" Rule is Clearly Insufficient to Ensure Qualified Plans are Comparable to Typical Employer Coverage or to the Chosen Benchmark, May Not Meet Patients' Clinical Needs, and is Likely to Lead to Discriminatory Benefit Designs

The Centers for Medicare and Medicaid Services (CMS) recently proposed that plans must offer at least one drug in each category or class offered by the benchmark plan, although specific drugs chosen for the formulary may vary.[15] This approach appears to assume that all drugs in each category or class are

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[10] T. Gibson et al. "Cost-Sharing, Adherence, and Health Outcomes in Patients with Diabetes." American Journal of Managed Care, August 2010.
[11] J.M. Abraham et al. "Gauging the Generosity of Employer-Sponsored Insurance: Differences Between Households With and Without A Chronic Condition." National Bureau of Economic Research, Working Paper 17232, July 2011.
[12] KRC Survey for Medicare Today, "Seniors' Opinions About Medicare Rx: Sixth Year Update" October 2011; CBO Medicare baselines for 2004 through 2011 available at www.cbo.gov.
[13] J.M. McWilliams et al. "Implementation of Medicare Part D and Nondrug Medical Spending for Elderly Adults with Limited Prior Drug Coverage," Journal of the American Medical Association, July27, 2011.
[14] C.C. Afendulis and M.E. Chernew. "State Impacts of Medicare Part D." American Journal of Managed Care, October 2011.
[15] This is analogous to suggesting that plan networks need only include one hospital in a region, regardless of whether the hospital offers neonatal intensive care or a neurology intensive care unit. Applying this type of restrictive standard only to prescription drug coverage is inconsistent with the ACA requirement that benefits are not unduly weighted toward any category § 1302(4)(A) .

substitutable, and that patients do not require a choice of treatment options. But the opposite is true. Drug classification systems place medicines into broad groupings in which medications are not generally substitutable. Inclusion of a single drug per therapeutic class is wholly inadequate to ensure access to necessary medicines and could lead to formulary designs that bear no resemblance to the level of coverage provided by the selected benchmarks, to typical employer coverage, or norms in the market today.

Further, the proposed standard would allow ample opportunity for benefit designs that would discourage enrollment of individuals with significant healthcare needs. The ACA non-discrimination requirement states that in order to be certified, QHPs must: "not employ marketing practices or benefit designs that have the effect of discouraging the enrollment in such plan by individuals with significant health needs".[16] ACA also specifies that benefits must not be designed in ways that discriminate based on age, disability, or expected length of life, but must consider the health care needs of diverse segments of the population.[17] These non-discrimination standards are intended to help ensure that high-cost, sick, or otherwise unique patients are not pooled in a few plans, thereby protecting patient access to care while promoting competition and protecting the stability of exchanges and plans operating within exchanges.

By effectively setting a new, government-defined "floor" for pharmacy benefits well below the existing norm, such a standard could not only allow outlier plan designs to be offered, but could reset market expectations and incentives that drive health plans to restrict coverage to a single drug in a therapeutic class. For example, a plan following this standard to the letter could gain an advantage over its competitors by discouraging the enrollment of individuals with significant health care needs (and therefore, high health costs), since the coverage offered would be inadequate by any reasonable measure of the patient's needs. Moreover, such patients are likely to be attentive to their coverage, making a formulary in technical compliance with this new standard not derived from market experience a discouragement to their enrollment. Once one plan gains a competitive advantage by avoiding these high risk individuals, other plans might have little choice but to follow suit and reduce their benefits to the same government-defined floor.

The following selected examples illustrate the serious risks to patients and the significant potential for discrimination against patients with particular high cost conditions should this standard be adopted.

- ***For many conditions, the recognized standard of care includes combination therapy involving multiple medicines in the same class, by definition exceeding one drug per class.*** For example, for adults and adolescents with HIV-1, clinical guidelines call for four different initial combination treatment regimens for treatment-naïve patients. These combination regimens have at least 2 drugs in the same USP class; if only one drug per USP class was available, HIV patients would not have access to the needed combination of drugs to treat their condition.[18]

  Likewise, in the instance of a patient being treated for diabetes, the standard of care often includes combination therapy with drugs that have complementary mechanisms of action in order to maintain a target blood glucose level, particularly as disease progression occurs.[19, 20] As all antidiabetic agents are grouped as a single class in the USP classification system, if any plan followed

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[16] ACA, § 1311(c) (1) (A) (emphasis added).
[17] ACA, § 1302(b)(4).
[18] Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents. http://www.aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-treatment-guidelines/11/what-to-start
[19] Handelsman Y et al., "American Association of Clinical Endocrinologists Medical Guidelines for Clinical Practice for Developing a Diabetes Mellitus Comprehensive Care Plan." American Association of Clinical Endocrinologists. 2011. Accessed on January 3, 2012 at: https://www.aace.com/sites/default/files/DMGuidelinesCCP.pdf.
[20] Guiding Principles for Diabetes Care: For Health Care Professionals, National Diabetes Education Program. 2009. Accessed on January 3, 2011 at: http://www.ndep.nih.gov/media/GuidPrin_HC_Eng.pdf.

the government-created minimum and offered only one drug per USP class, many patients would not have access to the needed combinations of drugs to treat their diabetes.

Similarly, clinical guidelines also recommend combination therapy for treatment of Hepatitis C. The standard of care has been to treat with ribavirin and peginterferon, with new data recommending the use of a direct-acting antiviral along with the other treatments.[21] Within the USP Model Guidelines, all of the antihepatitis treatments are grouped within one class making it possible that not all appropriate components of standard combination therapy would be available.

- ***Some drugs are approved by the FDA specifically for treatment of a condition after another drug in the class has been tried and failed.*** For example, Sprycel (dasatinib) is a molecular target inhibitor specifically approved by the FDA for treatment of chronic myelogenous leukemia that is resistant to or intolerant to prior therapy with other chemotherapeutic treatments, including Gleevec (imaitinib), another molecular target inhibitor that may be treated as in the same class.[22] Afinitor (everolimus) is a molecular target inhibitor approved for treatment of advanced renal cell cancer after failure of Sutent (sunitinib) or Nexavar (sorafenib).[23] Again, if only a single drug were available in the class, patients whose cancer had progressed or proven to be resistant to the initial chemotherapy would not have access to appropriate care.

  Similarly, two new antivirals for treatment of HIV, Selzentry (maraviroc) and Isentress (raltegravir potassium), are indicated for use in patients who have been treated with other HIV medications and have evidence of viral resistance. Though these two antiretrovirals work differently, they are grouped together in the same USP class. With the one drug per class requirement, it is possible that patients with HIV would not have the benefit of advanced treatments that could halt viral replication.[24]

- ***Medical Guidelines Call for Trying Different Agents to Control Conditions and Recommend Certain Drugs Not be Used by Certain Patients.*** The importance of providing choice of medicines for providers and patients is also evident in treatment guidelines. In treatment of high cholesterol, the patient's risk factors for coronary heart disease and lipid levels are evaluated as part of treatment selection. The National Cholesterol Education Program Adult Treatment Panel III guidelines for treatment of high cholesterol recommend that patients with high lipid levels and multiple risk factors for coronary heart disease, including diabetes, receive more intense treatment that will result in a larger percentage of lipid level reduction and result in coronary event risk reduction. Having multiple treatment options available is necessary to provide appropriate medication selection and to reach proper treatment intensity[25], as lipid lowering agents within a therapeutic class vary significantly in their potency. Conversely, a plan electing not to provide coverage that meets this evidence-based standard—for instance, by providing only one statin that is not sufficiently powerful to achieve the level of lipid reduction required—could discourage enrollment of these patients who are, by definition, sicker and a higher cost than average.

  Other treatment guidelines recommend that certain drugs not be used for certain patients. For example, monotherapy with beta-blockers, angiotensin-converting enzyme inhibitors and angiotensin II receptor blockers is less effective at lowering blood pressure in African Americans than in

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[21] Ghany MG, Nelson DR, et al. An Update on Treatment of Genotype 1 Chronic Hepatitis C Virus Infection: 2-2011 Practice Guideline by the American Association for the Study of Liver Diseases. Hepatology. October 2011. http://s3.gi.org/physicians/guidelines/AASLDHepCUpdate.pdf
[22] Lexi-Comp, Inc. (Lexi-Drugs™). Lexi-Comp, Inc.; January 11, 2012
[23] Lexi-Comp, Inc. (Lexi-Drugs™). Lexi-Comp, Inc.; January 11, 2012
[24] Lexi-Comp, Inc. (Lexi-Drugs™). Lexi-Comp, Inc.; January 11, 2012
[25] Grundy SM et al. Implications of Recent Clinical Trials for the National Cholesterol Education Program Adult Treatment Panel III Guidelines. Circulation. 2004; 110:227-239. Accessed on January 4, 2012 at: http://www.nhlbi.nih.gov/guidelines/cholesterol/atp3upd04.pdf

Caucasians, and angiotensin-converting enzyme inhibitors and angiotensin II receptor blockers are contraindicated for women who are or intend to become pregnant because of the risk of fetal developmental abnormalities.[26] Therefore, other blood pressure-lowering options should be available to meet the needs of these patients.[27] Statins should also not be used by women of child-bearing age because of the risk of fetal developmental abnormalities;[28] therefore, access to other cholesterol-lowering options should be available to meet the needs of these patients, yet all current options are grouped by USP into one class.

- ***Patients often respond to drugs in the same class differently, necessitating choice of medicines.*** For example, a study in *Health Affairs* reported that "drugs might not be equally effective for an individual patient. Prior studies have shown that failure to respond to one SSRI or having severe side effects does not mean that the patient will have the same experience with another SSRI."[29] In fact, one study showed that 26% of the people who did not respond to fluoxetine did have a response to sertraline.[30] Conversely, another study demonstrated that 63% of patients who failed treatment with sertraline did have a response to fluoxetine.[31] Efficacy of nonsteroidal anti-inflammatory drugs (NSAIDs) also varies amongst patients. These medicines are used to treat arthritis and other painful inflammatory conditions. Often, multiple medicines within the class must be tried before an adequate response is achieved. One study showed that 49% of patients being treated with NSAIDs had to switch to a different NSAID; 20% of patients switched two or three times; and 7% received four or more different NSAIDs.[32]

III. Virginia should establish clear and meaningful standards for comparing qualified health plans to the benchmark plan.

It will be important for health care quality reasons that the Commonwealth develop a clear methodology for comparing QHPs to the selected benchmark plan. The types of safeguards that assure high quality coverage include, among others, the following protections and requirements:

- Independent Pharmacy and Therapeutic (P&T) Committee review of not only formularies, but also utilization management (UM) requirements and newly approved treatments and indications to be added to existing formularies.[33]

- Review of formularies to ensure inclusion of a range of drugs in a broad distribution of therapeutic categories and classes and considers the specific drugs, tiering, and UM strategies employed in each formulary.

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[26] The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure. National Institutes of Health, National Heart, Lung, and Blood Institute. August 2004. Accessed on January 4, 2012 at: http://www.nhlbi.nih.gov/guidelines/hypertension/jnc7full.pdf

[27] While we reference these particular groups, we note that a large body of research finds that (a) most patients with hypertension require treatment with multiple different types of anti-hypertensives, all of which fall under USP's cardiovascular category, to control their blood pressure and (b) there is significant variation in individual patients' response to particular anti-hypertensives, thus indicating the importance of choice among therapies. Gupta AK, Poulter NR, Dobson J, Eldridge S, Cappuccio FP, Caulfield M, Collier D, Cruickshank JK, Sever PS, Feder G on behalf of ASCOT investigators. Ethnic differences in blood pressure response to first and second-line antihypertensive therapies in patients randomized in the ASCOT Trial. *Am J Hypertens* 2010; 23:1023–1030.

[28] Lexi-Comp, Inc. (Lexi-Drugs™). Lexi-Comp, Inc.; January 11, 2012

[29] Huskamp HA. Managing Psychotropic Drug Costs: Will Formularies Work? *Health Affairs*. 2003;22(5):84-96.

[30] Zarate CA, Kando JC, Toben M, et al. Does Intolerance or Lack of Response with Fluoxetine Predict the Same Will Happen with Sertraline? *Journal of Clinical Psychiatry*. 1996;57:67-71.

[31] Thase ME, Blomgren SI, Birkett MA et al. Fluoxetine Treatment of Patients with Major Depressive Disorder Who Failed Initial Treatment with Sertraline. *Journal of Clincial Psychiatry*. 1997;58:16-21.

[32] Jacobs J, Bloom BS. Compliance and Cost in NSAID Therapy. Hospital Therapy. 1987;supplement:32-39.

[33] Medicare Prescription Drug Manual, Chapter 6, § 30.2.2.

- An exceptions and appeals process that provide enrollees with the opportunity to obtain an exception when a needed drug is excluded from a plan's formulary or placed on a higher cost-sharing tier.[34]

- Formularies must include a broad range of treatment options for conditions that disproportionately affect vulnerable individuals, for example patients with mental illness, HIV/AIDs, and cancer.[35]

In their totality, these types of requirements generally provide robust drug coverage while protecting patients' access to the medicines they need and offering plans the flexibility to develop different formularies, and manage utilization and costs. Of course, even a consumer with an adequate formulary should have access to an easy to navigate appeals process so that when medically necessary medicines are not available on the formulary, they can access them. However, while an appeals process is an important backup safeguard, it is not a substitute for adequate coverage, as these systems place a significant burden on patients and physicians that can discourage their use.

We encourage the Commonwealth to outline a process or set of criteria to be used to ensure that coverage in qualified health plans is actually comparable to that in the benchmark plan. To make a reasoned judgment about the comparability of coverage requires a set of criteria that address multiple aspects of coverage, including the degree of choice available to patients and providers; processes for updating coverage to reflect newly available treatments; processes for exceptions and appeals; and protections for vulnerable populations. Such a process should both allow for flexibility and draw on current best practices in the commercial and employer-sponsored insurance market.

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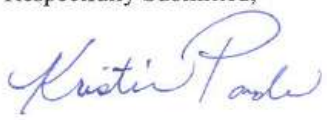
In conclusion, we appreciate the opportunity to provide comments on essential health benefits and your consideration of our comments. Please feel free to contact us with any questions.

Respectfully Submitted,



Kristin Parde

[34] Medicare Prescription Drug Manual, Chapter 18, § 30
[35] Medicare Prescription Drug Manual, Chap. 6 § 30.2.5.

March of Dimes Foundation

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Pat Simmons
State Director

COMMENTS ON THE VIRGINIA ESSENTIAL HEALTH BENEFITS PACKAGE TO THE VIRGINIA HEALTH REFORM INITIATIVE

June 8, 2012

On behalf of the March of Dimes, we appreciate the opportunity to submit written comments on the proposed Virginia Essential Health Benefits package benchmark plan. The March of Dimes Virginia Chapters have followed this issue with great interest and I wanted to let you know our priorities for the Essential Health Benefits package after reviewing the maternity and prenatal health coverage provided by the Anthem Virginia PPO Plan, which appears most likely to be chosen as the benchmark plan for Virginia. We hope you will take these thoughts into consideration before you make your final decisions.

The mission of the March of Dimes is to improve the health of women of childbearing age, infants, and children by preventing birth defects, premature birth, and infant mortality. Health insurance coverage affects how people use health care services. Therefore, the benefits and services that will be included in Virginia's Essential Health Benefits package will be of great concern to consumers.

The March of Dimes feels very strongly that in order to assure the best possible outcomes for mothers and their newborns and thereby provide the most cost-effective coverage in the long run, any benchmark plan should cover all of the maternity benefits corresponding to the American Congress of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics' (AAP) *Guidelines for Perinatal Care*. After reviewing the Anthem Virginia PPO Plan, we have the following observations:

The following benefits from the *Guidelines for Perinatal Care* either appear to be not covered by this plan or coverage is unclear:

Preconception care:

- Genetic counseling
- Review of pre-existing conditions
- Psychosocial support or non-biomedical factors that affect mental and physical wellbeing

Prenatal care:

- Parenting education
- Coordination of prenatal care with delivery services

Labor and delivery:

- Care in a facility appropriate for the patient's maternal-fetal risk

To be truly effective, maternity benefits must include services that span all the stages of pregnancy (including preconception and interconception):

- Prescription drugs
- Mental health services
- Psychosocial support services including case management, home care, and transportation
- Oral health
- Auxiliary services for women with physical disabilities

Also, the coverage description for Anthem Virginia PPO discusses co-pays for prenatal visits. However, under the ACA, all non-grandfathered plans must provide prenatal care with no co-pays. We are assuming that would be adjusted once the plan becomes the Virginia Essential Health Benefits package, but wanted to make that observation.

Again, as you make your final decisions for the coverage to be provided in the Virginia plan, please keep in mind that to be most cost-effective, maternity services need to include the full spectrum of preconception care, labor and delivery, and postpartum care. Women who receive preconception care are able to have access to screening and diagnostic tests that can help to identify problems early; services to manage developing and existing problems; and education, counseling, and referral to reduce risky behaviors like substance abuse and poor nutrition. Such care may help improve the health of both mothers and future babies. Postpartum care is vital to help women appropriately space pregnancies, thereby reducing the risk of preterm birth.

Thank you for your attention and consideration of our requests.

Yours truly,

Patricia G. Simmons

Pat Simmons
Chapter Director

June 7, 2012

Cynthia B. Jones, Director
Virginia Health Reform Initiative
Patrick Henry Building
1111 East Broad Street
Richmond, Virginia 23219

Dear Ms. Jones:

Thank you for the opportunity to provide written public comments prior to the June 13 VHRI meeting. The 1,500+ member Virginia Dietetic Association is committed to improving the health of the citizens of our commonwealth. It recognizes the important work underway to create the state health insurance exchange and define the benefits and coverage to be afforded to our fellow Virginians.

As you make decisions with regard to the essential health benefits, I strongly urge the Virginia Health Reform Initiative to

1. **Include access to nutrition services in the form of medical nutrition therapy (MNT) provided by registered dietitians (RDs) for adults and children**
2. **Provide for MNT with no co-pay or deductible for the patient, and**
3. **Grant RDs the capability to bill insurance directly for their services.**

1. Importance and affordability of MNT

RDs are the most cost-effective, qualified healthcare professional to provide MNT. MNT is distinct and different from nutrition education and requires advanced skills beyond those of other professionals. During an MNT intervention, RDs counsel clients on behavioral and lifestyle changes required to impact their long-term eating habits and health. Medical Nutrition Therapy includes:

- Performing a comprehensive nutrition assessment
- Determining the nutrition diagnosis
- Planning and implementing a nutrition intervention using the evidence-based nutrition practice guidelines
- Monitoring and evaluating an individual's progress over subsequent visits with the RD.

RD's provide care by applying the Academy of Nutrition and Dietetics Evidence-Based Nutrition Practice Guidelines. The Guidelines illustrate the best practice for MNT related to a specific disease or condition in order to achieve positive outcomes. Research on the cost-effectiveness and impact of MNT indicates:

- University of Virginia School of Medicine reported that an RD case-management approach to lifestyle care improved diverse indicators of health, including weight, waist circumference, health-related quality of life and use of prescription medications among obese person with type 2 diabetes. These results were seen with a minimal cost of $350 per year per patient.(1)

- A modest-cost, registered dietitian-led lifestyle intervention provided to people with diabetes and obesity reduced the risk of having lost work days by 64.3% and disability days by 87.2%, compared with those receiving usual medical care. For every dollar an employer invests in the lifestyle modification program for employees with diabetes, the employer would see a return of $2.67 in productivity. (2)

- Massachusetts General Hospital reported that participants who received group MNT provided by registered dietitians in a six-month randomized trial had a 6% decrease in total and LDL-cholesterol levels compared with the group not receiving MNT. The non-MNT group had no reduction in total cholesterol or LDL levels. The study revealed a savings of $4.28 for each dollar spent on MNT, much less than the cost of statin therapy. (3)

- The Lewin Group documented an 8.6% reduction in hospital utilization and 16.9% reduction in physician visits associated with MNT for patients with cardiovascular disease. The group additionally documented a 9.5% reduction in hospital utilization and 23.5% reduction in physician visits when MNT was provided to person with diabetes mellitus. (4)

- Prenatal nutrition programs that target high-risk pregnant women have been shown to improve long-term health outcomes in children, saving at least $8 for each dollar invested in the program. (5)

2. MNT with no co-pay or deductible

The Affordable Care Act requires certain insurance plans (new plans written after this law went into effect) to cover preventive services assigned a Grade A or B rating by the US Preventive Services Task Force at 100% without any co-pay or deductible. MNT meets this criteria. By waiving a deductible for MNT, **Virginians will have access to essential, cost-effective and preventative care.**

3. RD ability to bill insurance directly

According to the Institute of Medicine, *the registered dietitian is currently the single identifiable group of health-care professionals with standardized education, clinical training, continuing education and national credentialing requirements necessary to be directly reimbursed as a provider for nutrition therapy.* (6) Additionally, Medicare, Aetna, Cigna, Carefirst Blue Cross Blue Shield and United allow RDs to be providers in Virginia and bill directly for their services.

I strongly urge you to include RD-provided MNT services in Virginia's Essential Health Benefits package. Please feel free to contact me if you have any questions or need additional information.

Sincerely,

Martha M. Campbell, MA, RD
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References:

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Improving Lives • Finding the Cure

June 7, 2012

Ms. Cindi B. Jones
Director, Virginia Health Reform Initiative
Office of the Secretary of Health and Human Resources
Patrick Henry Building
1111 East Broad Street
Richmond, VA 23219

Re: Comments on the Essential Health Benefits for VHRI Advisory Council meeting on June 13, 2012

Dear Ms. Jones:

On behalf of the International Myeloma Foundation (IMF), the oldest and largest myeloma foundation dedicated to improving the quality of life of myeloma patients while working toward prevention and a cure, we are writing to submit comments on the Essential Health Benefit implementation concerns that the Virginia Health Reform Initiative Advisory Council is considering at its meeting on June 13, 2012.

Background about Myeloma and its Treatments

The second most common blood cancer worldwide, multiple myeloma (or myeloma) is a cancer of plasma cells in the bone marrow. It is called "multiple" because the cancer can occur at multiple sites in multiple bones. Each year approximately 20,000 Americans are diagnosed with myeloma and 10,000 lose their battle with this disease. Once a disease of the elderly, it is now being found in increasing numbers in people under 65. At any one time there are over 100,000 myeloma patients undergoing treatment for their disease in the U.S. Although the incidence of many cancers is decreasing, the number of myeloma cases is on the rise. There is no cure for myeloma, remissions are not always permanent, and additional treatment options are essential. Fortunately, we have seen dramatic and important advances in treatments for multiple myeloma.

Treatments for myeloma include three chemotherapy products, one injectable and two administered orally, and stem cell transplants. (The term "chemotherapy" is a specific type of cancer treatment that uses drugs to kill cancer cells. It works by stopping or slowing the growth of cancer cells, which otherwise divide quickly.) Anti-cancer therapies can be given to cure cancer, control it, or ease cancer symptoms. In the past, chemotherapy was primarily delivered by IV or injection but oral drugs have become the standard of care for many cancer types, including myeloma. Some patients respond better to IV treatments and/or have fewer side effects, and some oral anti-cancer medications do not have IV equivalents due to how the body would metabolize the medications. Myeloma is a recurring disease, so patients typically cycle through all of the treatment options as they attempt to control their cancer.

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www.myeloma.org

Insurance coverage has lagged behind the proliferation of oral anti-cancer medications in particular. Although oral cancer treatments have become more readily available and the standard of care in many cases, insurance plans often have extremely high cost-sharing requirements for oral medications. IV chemotherapy is typically covered under a plan's medical benefits, which requires patients to pay an office visit co-payment. Oral chemotherapy is typically covered under a plan's prescription drug benefit, which can require significant co-insurance. Inadequate insurance, which includes plans with high cost-sharing, is a barrier to patients having access to life-saving cancer treatment.

Specific Comments about Essential Health Benefits in Virginia

At the outset, we note that existing Virginia law requires individual and small group policies to provide parity for orally administered cancer chemotherapy drugs (§38.2-3407.18). Plans that cover cancer chemotherapy drugs administered orally and intravenously or by injection will provide that the criteria for establishing cost-sharing principles are consistently applied within the same plan for the different methods of delivery. The EHB Analysis was performed prior to the enactment of this requirement, but we believe that this coverage requirement applies to all of the benchmark plans. Thus, parity for oral chemotherapy drugs (as mandated by existing Virginia law) falls within the scope of state-mandated benefits included in the EHB. We encourage you to pick a benchmark plan that does include parity for oral chemotherapy drugs.

The remainder of our comments represents other concerns to ensure that the EHB package in Virginia meets the needs of individuals with myeloma and other cancers: access to all therapies in a category or class and access to providers.

Access to Therapies

We are very concerned that under the HHS approach, insurance plan prescription drug formularies are permitted to offer only one drug in each category or class. This proposed requirement falls short of Medicare's requirements and is likely to result in inadequate coverage. This requirement also fails to satisfy the ACA requirement that the EHB package be modeled after the typical employer-sponsored insurance plan, which generally covers more than one drug per class or category of drugs. We ask that you require plans to cover all the drugs in each class or category that are covered by the benchmark plan.

There are several reasons for which covering only one drug in each category or class is inadequate for cancer patients. Patients must have access to the most appropriate therapies for their diseases. First, if the one covered drug is not optimal for a particular patient, adverse side effects may result. Moreover, cancer drugs are not interchangeable and individual patients respond differently to different treatments, and frequently cycle through several regimens during the course of treatment. Also, it is critical that commonly prescribed off-label uses for cancer treatment are included in the EHB package. Off-label anti-cancer drugs are currently covered under Medicare Part D, if the use is supported in designated compendia. Finally, the emergence of personalized medicine and the increasing use of targeted cancer therapies mean that some treatments will only be effective for patients with a particular genetic profile or if their diseases have a particular molecular profile.

If only one drug in a class or category is available, myeloma patients will be limited in their covered treatment options and may not have access to the most effective treatments. Therefore, the IMF believes strongly that all appropriate therapies must be covered, and more than one drug in a class must be available.

Access to Providers and Comprehensive Services
Individuals with myeloma need access to comprehensive diagnostic and treatment services, including a written care plan and all elements of multi-disciplinary care. This care may not perfectly correlate to a broad EHB "bucket" such as hospitalizations or ambulatory services. This multi-disciplinary care includes injectable and oral chemotherapy and stem cell transplants and clinical trials for appropriate candidates. EHB must require adequate networks for cancer patients that include Commission on Cancer-accredited programs and/or NCI-designated cancer centers or care by out-of-network physicians and other health care providers, if in-network care does not meet the medical needs of the patient. Finally, individuals with myeloma and their families must have access to supportive care, symptom management, and palliative care from the time of diagnosis and across the continuum of care, including but not limited to services provided through hospice.

Conclusion
IMF believes that all cancer patients should have access to the anti-cancer regimens recommended by their physicians and should not be forced to choose a less appropriate treatment option simply because of inordinate out-of-pocket costs for a more appropriate type of therapy or mechanism of delivery. To that end, a well-designed EHB package must provide balanced coverage for all aspects of cancer treatment from preventive care to diagnostic tests to treatment options such as chemotherapy and stem cell transplants to palliative care. Balanced coverage is central to efforts to ensure that health reform meets its potential to allow Americans to diagnose and to treat cancer and other diseases, improve health, and bend the cost curve.

If you have any questions or need further information about how to ensure that EHB meets the needs of patients with myeloma and their families, please contact Arin Assero, Director of Advocacy at aassero@myeloma.org or 818-487-7455.

Sincerely,

Susie Novis

Susie Novis
President, International Myeloma Foundation

DentaQuest

TO: THE VIRGINIA HEALTH REFOM INITIATIVE

FROM: DENTAQUEST

SUBJECT: COMMENTS ON VIRGINIA'S ESSENTIAL HEALTH BENEFITS BENCHMARK

DATE: 6/7/2012

DentaQuest appreciates the opportunity to submit feedback to the Virginia Health Reform Initiative relative to the Commonwealth's efforts to select a viable essential health benefits benchmark plan. The VHRI subcommittee on the Essential Health Benefit (EHB) has been working diligently to develop recommendations to the larger Initiative on the best EHB benchmark plan for Virginians. DentaQuest commends the efforts of the subcommittee and offers the following comments specific to the essential pediatric dental benefit which we believe will align with the subcommittee's overall recommendations.

As you know, HHS has instructed each state to select a benchmark plan to define the EHBs. In its initial guidance to states, HHS indicated that pediatric dental services are one of the few mandated benefits that are often not covered by the benchmark plan options. For this reason, HHS has given states two additional options to supplement their benchmark plan with appropriate dental benefits for children. The two options are:

- The state's separate CHIP program[1] or
- The Federal Employees Dental and Vision Plan (FEDVIP) dental plan with the largest national enrollment.

An initial review of the 10 benchmark plan options being considered in Virginia reveals that children's dental coverage is a missing component of the majority of plans. In fact, only the Federal Employee Health Benefit Plan (FEHBP) Standard Option covers services, like basic fillings, that go beyond minimal basic care. In order to ensure that Virginia's children – especially low-income children eligible for subsidies via the exchange – have access to meaningful dental services that help mitigate disease and improve overall health, the VHRI should recommend that the Commonwealth select an essential pediatric dental benefit benchmark that mirrors the CHIP program, Smiles for Children.

In the United States, dental disease is the most common chronic illness in children – it is five times more common than asthma – and yet, dental disease is preventable. The essential pediatric benefit in Virginia should be comprehensive, evidence-based and individualized based on patient risk. A flexible benefit based on CHIP standards will provide children with an adequate level of care for their unique needs while at the same time ensuring that coverage is affordable. High-risk patients with a significant level of untreated disease can receive more intensive services while a child with excellent oral health can receive a more appropriate level of care for his/her needs.

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[1] In its initial guidance, HHS indicates that if a state does not have a separate CHIP program, it may establish a dental benchmark that is consistent with applicable CHIP standards.

Additionally, establishing a comprehensive and flexible benefit based on CHIP will help alleviate coverage disruptions for those children who are likely to experience income fluctuations and transition between Medicaid/CHIP and the exchange. This is a critically important element for those on the lower level of the income eligibility scale.

Thank you again for the opportunity to provide comments on this very important topic. We look forward to continued collaboration. Please contact Kristin LaRoche, government relations associate, at kristin.laroche@improvingoralhealth.com or 617-886-1458 with any questions or feedback.

About DentaQuest

DentaQuest is committed to improving the oral health of the nation's neediest residents. In Virginia, DentaQuest proudly collaborates with the state to administer the Smiles for Children program. In addition to dental benefits administration, DentaQuest engages in oral health research and philanthropy through separate business units. The DentaQuest Institute is a national, non-profit organization providing clinical care and practice management solutions. The DentaQuest Foundation endeavors to increase access to dental care for the underserved.

On behalf of the Alliance of Virginia Dental Plans (Alliance), thank you for the opportunity to provide comments and information on the decisions pending before the Virginia Health Reform Initiative. The Alliance is a coalition of companies who are authorized to sell dental benefits in Virginia. The Alliance supports the development of an Exchange and marketplace that provides strong consumer choice and a variety of purchasing options.

Dental benefits vary significantly from traditional medical insurance in policy structure, cost, coverage and market penetration. These differences are critical to balancing coverage, affordability, and simplicity in developing the Essential Health Benefits and determining appropriate market rules applicable to qualified dental plans.

While most large employers (more than 100 employees) include medical and dental coverage as part of the health benefits package offered to employees, only 48% of all small employers now offer dental coverage. Where dental coverage is offered in the small group market, it is, in many cases, offered on an employee-pay-all (voluntary) basis. Therefore, the inclusion of pediatric oral services will be an expansion of coverage in much of the small employer market, and potentially an extra cost to employers.

Dental benefits are usually sold and purchased as a separate product; distinct and apart from medical coverage. In the private market (not including public programs), roughly 98 percent of Americans with dental coverage today have a dental benefit policy separate from their medical policy. Less than two percent of Americans get their medical and dental policies integrated (or embedded) into a single policy with medical coverage. These policies cover individuals or families. "Child-only" policies are rarely offered in the current dental market. Recognition of the separate nature of dental coverage is critical to affording consumers in all markets equitable access to affordable, quality dental coverage and allowing them to keep the coverage they have, as promised during the passage of the ACA.

Given the separate nature of dental benefits in the current marketplace, the selected benchmark plan for health benefits is not likely to include dental coverage. As a result, the State will have to separately identify the benchmark for the required dental coverage. We ask that Virginia carefully balance the affordability of the pediatric dental benefit with the coverage. It is certainly welcome for children in the small employer and individual market to have access to dental benefits. Although many small employers do offer such coverage for families today, premiums are often paid entirely by the employee. This new benefit will not include typical cost containing features such as annual or lifetime maximums so it should be designed to not exceed pricing tolerance in the intended market. Virginia may also consider that if pediatric benefits are too robust or costly, adults may drop their own coverage and simply cover their children. This could reduce adult access to dental care, with potential impacts on their oral and overall health. Lastly, the benchmarks for dental proposed by HHS are not typical of the small employer market. We recommend thatVirginia look at typical small employer dental plans when determining the essential pediatric dental benefit.

Again, thank you for the opportunity to comment. Should you have any questions, please do not hestitate to contact me.
Kimberly Y. Robinson, Esq.

UNITED CONCORDIA®
Insuring America's Dental Health

June 7, 2012

The Honorable William A. Hazel, Jr., M.D.
Secretary of Health and Human Resources
Commonwealth of Virginia
1111 East Broad Street, Suite 4001
Richmond, VA 23219-1922

Submitted electronically via: VHRI@governor.virginia.gov

Re: Essential Health Benefits

Dear Secretary Hazel:

United Concordia Dental appreciates the opportunity to submit comments on "Essential Health Benefits" for products that will be offered both on and off Virginia's AHBE and SHOP exchanges.

United Concordia Dental is a leading national dental carrier that delivers high-quality cost-effective dental programs focused on improving oral health to 6 million members nationwide including more than 195,000 Virginians. Our primary mission is to help improve the oral health of not only our members, but also the communities within which we live and work. Through collaboration with local organizations, groups and individuals, we reach out to our communities to help those in need access dental health care.

The Patient Protection and Affordable Care Act (ACA) expressly allows stand-alone dental plans to be offered in the individual and SHOP exchanges if they provide the pediatric oral services required as part of the Essential Health Benefit Package (EHB). These dental plans may be offered either independently or together with QHPs that cover the balance of the EHB (*ACA Section 1311(d)(2)(B)(ii); 45 CFR 155.1065(b)*). An exchange must permit both options.[1]

While the *Essential Health Benefits Bulletin* and *Frequently Asked Questions Essential Health Benefit Bulletin* (released December 16, 2011 and February 17, 2012 respectively) point toward future guidance, United Concordia Dental supports the VHRI's efforts to develop recommendations for the General Assembly. To this end, United Concordia Dental recommends the following:

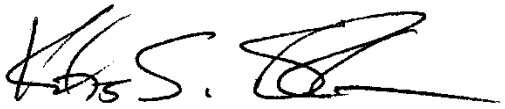
- **Select a pediatric dental benchmark that balances affordability and coverage: any of the largest three by enrollment commercial small group dental programs.** The design and cost of pediatric oral services have broad implications for continuity of coverage for those Virginians (both children and adults) who currently have public or private dental coverage, and access for children who do not currently have coverage. A *dental-specific* small employer plan as a benchmark for pediatric dental provides greater flexibility than "filling in" the missing pediatric oral services using the Federal Employees Dental & Vision Program (FEDVIP) or CHIP benchmarks.

- **Establish a minimum actuarial value of 80% (gold) for pediatric dental benefits offered through an Exchange, whether by a stand-alone dental plan or a QHP.** The actuarial value of a typical children's dental plan will be in the gold or platinum level. Reducing the actuarial value of the pediatric dental benefits to the silver level would require increasing the patient cost-sharing above 50% for some benefits, making them "illusory."

- **Virginians with dental coverage should not be required to purchase duplicative coverage.** A goal of the ACA is to expand access for those not covered while allowing the continuity of coverage and care for those who have coverage today. When small employers bring their employees to Exchanges for medical coverage, the stand-alone dental benefits they provide for their employees outside the Exchange should be accepted if they meet Virginia's benchmark established for pediatric dental. In addition there will be instances when children with two parents or guardians will have dental coverage through the parent or guardian working for a large employer. In this instance, the parent or guardian working for a small employer should not be required to purchase duplicative dental coverage for the children.

The enclosed document addresses each of these statements in further detail. Thank you for consideration of our suggestions. Should you or the VHRI Advisory Council have any questions about our comments, please feel free to contact me at 717-260-6983 or kurtis.shook@ucci.com.

Sincerely,



Kurtis S. Shook
Director, Health Care Reform Exchanges
United Concordia Dental

Enclosure

[1] *See HHS discussion of 45 CFR 155.1065(b) in Analysis and Responses to Public Comments published with Final Rule on the Establishment of Exchanges and Qualified Health Plans, pg 18411 of Federal Register, Vol. 77, No. 59, March 27, 2012*

Attachmen

EHB Dental Benchmarks

United Concordia Dental appreciates the opportunity to submit comments on "Essential Health Benefits" for products that will be offered both on and off Virginia's AHBE and SHOP exchanges.

In the December 16, 2011 *Essential Health Benefits Bulletin* HHS outlined four health benefit benchmarks including policies from small employers, state employees, the Federal Employees Health Benefits Program (FEHBP) and non-Medicaid HMOs. HHS also included two benchmarks for dental when pediatric dental is "missing" from these health-specific benchmarks. The dental benchmarks include the Federal Employees Dental & Vision Program (FEDVIP) and the state's Children's Health Insurance Plan (CHIP). In addition, HHS noted that it intends to propose "medically necessary" orthodontia as part of the EHB package.

Of the four health options, FEHBP is the only benchmark that includes pediatric dental coverage. Both the Blue Cross Blue Shield FEHB Basic and Standard plans include preventive and restorative dental procedures. However, the higher cost sharing results in patients receiving less value than typical dental coverage[i]. The two dental-specific benchmarks, FEDVIP and CHIP cover similar services; however, FEDVIP was designed with federal employees (adults) in mind and CHIP has no consumer cost sharing. Neither benchmark parallels typical private market dental plans. HHS has not specifically included a benchmark that reflects pediatric dental in a typical employer policy per ACA §1302(b)(2)(A).

With the inclusion of the dental specific benchmarks, HHS implies that "pediatric oral services" are tied to typical dental plans. However, since the benchmarks that are used are atypical, United Concordia Dental recommends that the Commonwealth consider any of the three largest small employer *dental* plans as a benchmark for pediatric dental just as the default for health coverage is largest medical plan by enrollment in the State's small group market.

Select a Pediatric Dental Benchmark that Balances Affordability and Coverage

HHS noted in the *Essential Health Benefits Bulletin* that it "sought to balance comprehensiveness, affordability, and State flexibility and to reflect public input to date." United Concordia Dental agrees with the importance of balancing these goals to assure that a range of high-quality, affordable health and dental coverage choices is available to consumers in a competitive market. *United Concordia Dental recommends selection of any one of the three largest (by enrollment) small group dental plans.*

The design and cost of pediatric oral services have broad implications for continuity of coverage for those Virginians (both children and adults) who currently have public or private dental coverage, and access for children who do not currently have coverage. Through 2008, 57% of the U.S. population had dental coverage—a percentage that had been relatively stable for several years. Although nationwide enrollment declined in 2009, largely a result of the economy, it rebounded in 2010 to 57%. (Note: during this period both new and in-force premiums rose only by 1% to 4% depending on the type of product.) National Association of Dental Plans (NADP) consumer survey data confirm there is high consumer price sensitivity to premium increases for dental coverage.[ii]

It is essential that the children's EHB package not be so costly as to deter families from selecting dental coverage. Affordable access to preventive dental services and early diagnosis necessary to reduce dental disease and expensive treatment is, after all, one of reasons that dental coverage was deemed to be an essential health benefit in the Affordable Care Act.

So how much do dental plans cost? The NADP commissioned Milliman (an independent actuarial and benefit firm) to estimate monthly premium costs for the pediatric dental benchmarks outlined in HHS guidance. The estimates assume no annual or lifetime limits, no deductible on class I (diagnostic & preventive) services, coverage of child related services for ages up to 21, and national average costs. To date, HHS has not defined "medical necessity" for orthodontia, and States vary widely in their parameters for orthodontia in public programs. As such, the illustrative costs for "medically necessary" orthodontia are shown as a range. The most restrictive definition provides coverage only for treatment of cleft palate, a mid-range Salzmann score (e.g., a 42 which is used in California and Illinois; 40 in Oregon) provides coverage for treatment of severe or handicapping malocclusion and low threshold (e.g., Salzmann score of 25, which is the current Pennsylvania index for CHIP) allows treatment whenever indicated by a dentist. United Concordia Dental's opinion is that a Salzmann index should be **at least** 32-35 otherwise utilization of orthodontic services will be high and the premium will be relatively unaffordable for those consumers who purchase coverage on the Exchange. Currently under *Smiles for Children,* Virginia's Medicaid/ FAMIS/FAMIS Plus dental program, a patient must meet minimum Salzmann index of 25 or medical criteria and have prior approval. The cost increases shown below for the pediatric dental benchmark selected by Virginia could be higher or lower depending on the definition that is used for medical necessity.

2014 Illustrative Premiums per Child up to Age 21 in Addition to Medical[iii]

Benchmark	Description	Without Ortho		With Midlevel MN Ortho	
		Per Child Per Month	Per Child Per Year	Per Child Per Month	Per Child Per Year
Typical Small Employer Dental Plan (not currently allowed as benchmark)	**Common Small Employer DPPO without Ortho** $1,000 Annual Maximum; In Network: 100/80/50 with $50 deductible; Out-of-network: 80/60/40 with $50 deductible on class I & II services [iv]	$21.00	$252	$23.80	$285.60
FEHBP Plan with Largest Enrollment (BCBS Standard)	**Schedule of Covered Dental Procedures** including Diagnosis/Prevention/Emergency/Restorative & Extractions with scheduled payment based on age. Any services not listed are non-covered benefits**.**	$4.50	$54	$7.30	$87.60
FEDVIP Dental with Largest Enrollment (MetLife)	**DPPO** no Annual Maximum[v]; 100/70/50 in-network & 90/60/40 out of network with $50 deductible. *(NOT INCLUDED—The MetLife plan includes 50% coinsurance on ortho up to age 19 with a 24 month waiting period and $3500 lifetime limit. To add ortho to this cost, see ortho 50/50 add-on below.)*	$24.50	$294	$27.30	$327.60
State CHIP Program	**CHIP Equivalent** [vi] no annual maximums or cost-sharing	$29.25	$351	$32.05	$384.60
Medically Necessary (MN) Orthodontia	**Ortho @ 50% coinsurance**[vii] *(cost depends on the definition of "medical necessity*[viii]*")*	$0.40 - $9.40	$4.80 - $112.80		
	Ortho with 100% coverage[ix] *(cost depends on the definition of "medical necessity with no coinsurance)*	$0.80 - $18.75	$9.60 - $225		

The ACA requirement of pediatric dental within the EHB changes the dynamic of coverage. Currently, employers offer dental benefits to their employees with the election to have their families covered. In 2014, the policy will be issued for the child with the adults as additional coverage. Therefore if the cost of the children's coverage is excessive, parents/guardians may not continue dental coverage for themselves. Based on consumer surveys, NADP has projected half of adults with employer-provided dental coverage in the small group market today would drop coverage if their dental coverage is separated from their children's coverage and the cost of the children's coverage is substantial.[x]

With the Surgeon General's finding that dental coverage results in more dental visits by both adults and children and the more recent linkages of oral and overall health, any degradation of dental coverage will have an overall negative impact on oral health, overall health and the cost of health coverage. A recent landmark study, conducted by Professor and Dean Emeritus Marjorie Jeffcoat, D.M.D., of the University of Pennsylvania, School of Dental Medicine, in partnership with United Concordia Dental and Highmark, looked at medical and dental claims data of people with Type II diabetes from a pool of 1.7 million individuals. The research found, based on three years of study data, that each diabetic member who treated their gum disease:

- Saved an average of $1,814 in medical costs annually
- Had an average reduction of 33% in annual hospital admissions
- Had an annual average of 13% fewer physician visits

Therefore, allowing families to stay together while providing high quality dental policy options with affordable costs is critical.

Establish a Minimum Actuarial Value of 80% for Pediatric Dental Benefits Offered Through an Exchange, Whether by a Stand-alone Dental Plan or a QHP

Issuers offering QHPs in an exchange must offer at least one plan at each of the silver and gold levels of coverage, having 70% and 80% actuarial values respectively (*ACA Section 1301(a)(1)(C)(ii); 45 CFR 156.200(c)(1)*). *This certification standard should not be applied to stand-alone dental plans.*

The actuarial value of a typical children's dental plan will be in the gold or platinum level. Reducing the actuarial value of the pediatric dental benefits to the silver level would require increasing the patient cost-sharing above 50% for some benefits, making them "illusory."

Further, if a silver coverage level is required, QHP issuers may be tempted to reduce the pediatric dental benefits and provide small offsets on the medical side to meet that actuarial value. This would defeat the purpose of including meaningful pediatric dental care as an essential benefit in the ACA. This shifting of value between medical and dental benefits can be avoided if there is a separate minimum prescribed actuarial value for pediatric dental benefits. This is also another reason why QHPs should be required to separately price and offer the essential pediatric dental benefits. If medical benefits and dental benefits are priced and offered separately, the Exchange can ensure there are adequate essential pediatric dental benefits offered to Virginians. Because pricing and offer transparency is in the best interest of Virginia consumers, the Exchange should establish it as a standard for QHP certification.

United Concordia Dental recommends a minimum actuarial value of 80% (gold) for pediatric dental benefits offered through an Exchange, whether by a stand-alone dental plan or a QHP rather than applying both the silver and gold level requirements. This minimum actuarial value should be calculated on the essential pediatric dental benefits based on the projected use by pediatric-age enrollees. The use of pediatric-age enrollees as the standard population to calculate the actuarial value of a child-only benefit helps to accurately portray the value of a plan for the intended recipients of coverage. If the VHRI Advisory Council or the General Assembly believes that it needs to create an actuarial value indicator above the minimum actuarial value for stand-alone dental plans, a feasible alternative would be "high" and "low" options, with the low option being the minimum actuarial level of coverage.

Virginians with Dental Coverage Should not be Required to Purchase Duplicative Coverage

A goal of the ACA is to expand access for those not covered while allowing the continuity of coverage and care for those who have coverage today. *United Concordia recommends that when small employers bring their employees to Exchanges for medical coverage, the stand-alone dental benefits they provide for their employees outside the Exchange should be accepted if they meet Virginia's benchmark established for pediatric dental.* In addition there will be instances when children with two parents or guardians will have coverage through the parent or guardian working for a large employer. In this instance, the parent or guardian working for a small employer should not be required to purchase duplicative coverage for the children.

Requiring coverage for children's dental within the EHB, changes the dynamic of coverage. Currently, employers offer dental benefits to their employees with the election to have their families covered. Now, the policy is issued on the child with the adults as additional coverage. Therefore if the cost of the children's coverage is excessive, parents may not continue dental coverage for themselves. Based on consumer surveys, NADP has projected half of adults with employer-provided dental coverage in the small group market today (11 million) would drop coverage if their dental coverage is separated from their children's coverage and the cost of the children's coverage is substantial. With Pew Institute's estimate that 5.3 million children will be added to programs providing dental coverage – most in public not commercial dental plans – the net loss in coverage and reduction in access to dental care could be significant.

A considerable amount of literature exists pointing to an association between dental disease and certain medical conditions, including diabetes, heart disease, stroke, and premature or low birth weight infants. Therefore, allowing families to stay together while providing high quality dental policy options with affordable costs is critical for Virginians.

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[i] One interpretation of the Bulletin's language suggests if "pediatric oral services" is "missing" from all the selected medical benchmarks, a state should utilize the additional dental benchmarks included in the Bulletin. However, as one of the medical benchmarks, i.e. the FEHBP most common policy, includes dental coverage, another interpretation is that states would always use FEHBP and be precluded from using the two specific dental benchmarks.

[ii] NADP/DDPA White Paper: "Offering Dental Benefits in Health Exchanges: *A Roadmap for Federal and State policymakers"* September 2011 pg. 36-37, Dallas, TX.

[iii] Costs developed by Milliman for NADP as a national average. Costs will vary by geographic area. Assumptions included that no annual maximum would be applied, no deductible for class I (diagnostic & preventive) services, pediatric services provided to age 21, and national average costs.

[iv] If the standard dental deductible is not utilized and the $2,000 ACA annual deductible is coordinated with a medical plan, the cost of dental coverage could be decreased by as much as half.

[v] Actual annual limit of the MetLife FEDVIP DPPO for 2012 is $10,000. No annual maximum is used for the 2014 illustrative prices as HHS regulations indicate that annual maximums cannot be used on any of the essential benefits.

[vii] As administered today with a separate annual limit, orthodontic claims are subject to 50% coinsurance. Although the full lifetime limit is usually paid on each claim, there is significant cost sharing for the procedure. Since it is unclear whether cost sharing will be allowed for "medically necessary" orthodontic treatment, Milliman developed estimated premium for no coinsurance as well.

[viii] The range of costs for orthodontic treatment was based on the following range of alternatives derived from state CHIP programs. Lowest estimate is based on coverage for orthodontic treatment for cases of cleft palate only. The middle estimate is based approximates the application of a mid-range Salzmann index to reflect a National Center for Health Statistics study that found 29% of pediatric population had a handicapping to severe malocclusion. The high range is the provision of an orthodontic benefit as it is administered today without regard to medical necessity.

[ix] See Endnote vii

[x] See Endnote ii